

WRITE PLAINLY—USE UNFADING BLACK INK—MAKE A PERMANENT RECORD

DEPARTMENT OF COMMERCE
BUREAU OF THE CENSUS

STATE BOARD OF HEALTH OF MISSOURI
STANDARD CERTIFICATE OF DEATH

17142

State File No.

Registrar's No. 2217

FILED JUN 7 1948

Registration District No. 449

Primary Registration District No. 1002

1. PLACE OF DEATH:

(a) County Jackson
(b) City or town J. E. Mo
(c) Name of hospital or institution: University of Mo.
(If not in hospital or institution, write street number or location)
(d) Length of stay: In hospital or institution 4 hrs
In this community 4 hrs
(Specify whether years, months or days)

3. (a) PRINT FULL NAME

John Joseph Shelley
3. (b) If veteran, name war no 3. (c) Social Security No. no

4. Sex Male 5. Color or race wh 6. (a) Single, widowed, married single
6. (b) Name of husband or wife none 6. (c) Age of husband or wife if alive 5-11-43 years (Month) (Day) (Year)

7. Birth date of deceased 5-11-43

8. AGE: Years 4 hrs Months Days If less than one day hr. min.
9. Birthplace J. E. Mo (City, town, or county) (State or foreign country)

10. Usual occupation none

11. Industry or business Edward C. Shelley
12. Name J. E. Mo
13. Birthplace J. E. Mo (City, town, or county) (State or foreign country)
14. Maiden name Jane Drew Shouhart
15. Birthplace J. E. Mo (City, town, or county) (State or foreign country)

16. (a) Informant Mrs J. Shelley
(b) Address 3915 Charlotte
17. (a) Burial (b) Date thereof 5-12-43
(Burial, cremation, or removal) (Month) (Day) (Year)

(c) Place: burial or cremation St. Marys
18. (a) Signature of funeral director Quinn & Sohn
(b) Address 20 W. Linwood
19. (a) 5-12-43 (b) M. M. Crome
(Date received local registrar) (Registrar's signature)

2. USUAL RESIDENCE OF DECEASED:

(a) State Missouri (b) County Jackson
(c) City or town Kansas City
(If outside city or town limits, write "RURAL")
(d) Street No. 3915 Charlotte
(If rural, give location)
(e) Citizen of foreign country? no (Yes or No)
If yes, name country

MEDICAL CERTIFICATION

20. DATE OF DEATH: Month May day 11
year 1943 hour 9 minute 20 P M.
21. I hereby certify that I attended the deceased from 5-11-43 to 5-11-43
that I last saw him alive on 5-11-43
and that death occurred on the date and hour stated above.

Immediate cause of death Potential Torsion Aorta
Duration 9 hrs

Due to Conjunctive
Due to 157E
Other conditions (Include pregnancy within 3 months of death)

Major findings: Of operations none
autopsy none
PHYSICIAN

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide (specify)
(b) Date of occurrence
(c) Where did injury occur? (City or town) (County) (State)
(d) Did injury occur in or about home, on farm, in industrial place, in public place?

While at work? (Specify type of place) (e) Means of injury
23. Signature Ed Sheldon (M. D. or other)
Address 322 W. 11th Date signed 5-11-43

STATEMENT BY LICENSED EMBALMER

I hereby certify that the body whose name is recorded on the reverse side of this certificate was embalmed by me, or by.....

....., Registered Apprentice No.....,
working under my personal supervision.

Signed.....

Charles M. Quirk

Licensed Embalmer No.....

3774

P. O. Address.....

R. C. Moore

Note: The above MUST BE SIGNED BY THE LICENSED EMBALMER in his OWN HANDWRITING. (Failure to comply with the above constitutes grounds for revocation of license.)

If this body is not embalmed, fact should be so stated above.